

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
Ragwitek Immunotherapy

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992**

CRITERIA:

- Client must be between 18 and 65 years of age
- Provide documentation of a diagnosis of ragweed pollen-induced allergic rhinitis confirmed by positive skin test, or in vitro testing, for pollen-specific IgE antibodies for short ragweed pollen.
- Therapy must be initiated at least 16 weeks before the expected onset of each ragweed pollen season. (December 5 to January 10)
- First dose must be administered under supervision of a physician with experience in the diagnosis and treatment of allergic diseases. Letter of medical necessity or progress notes must document that patient will be observed, in the office for at least 30 minutes following the initial dose.

AUTHORIZATION:

- One year

RE-AUTHORIZATION:

- Client age between 18 and 65 years of age.
- Initial therapy was approved and initiated at least 12 weeks prior to expected onset of ragweed pollen season.
- Therapy has been continuous throughout ragweed pollen season.
- If all other criteria have been met Ragwitek may be approved for daily therapy for three consecutive years.

08/21/2015

<https://medicaid.utah.gov/pharmacy/>